Designing an aligned operating model around the patient journey

By Cornelia Vremes *MBA, EdD*

Medical practices invest considerable effort in strategic planning, staff development, technology selection, and performance reporting. Too often, those efforts happen separately, led by different people, on different timelines and measured against different standards. The result is a set of well-intentioned initiatives that do not reinforce one another.

An operating model can connect those efforts into a single system. In this model, five domains make up that system: Purpose, People, Process, Platform, and Performance. Purpose provides the strategic foundation; the other four are where strategy shows up in daily operations. Figure 1 presents the five domains and the question each one answers. Purpose sits at the center because it guides the other four.

Whether these domains work as a system depends on how the practice organizes them. Practices often define them by department: staffing by function, workflows by team, systems by user group and performance by cost center. That describes the organization, but it does not show how the pieces connect around the patient's experience.

Organizing the same domains around the patient journey changes the view. Here, the patient journey means the stages a patient moves through from first awareness of the practice to an ongoing relationship, using labels such as attraction, engagement, assessment, activation, delivery and nurture. The exact stages and labels should vary by specialty and care model. The goal is to map each domain to each stage so leaders can see how people, workflows,

FIGURE 1. FIVE DOMAINS OF AN ALIGNED OPERATING MODEL

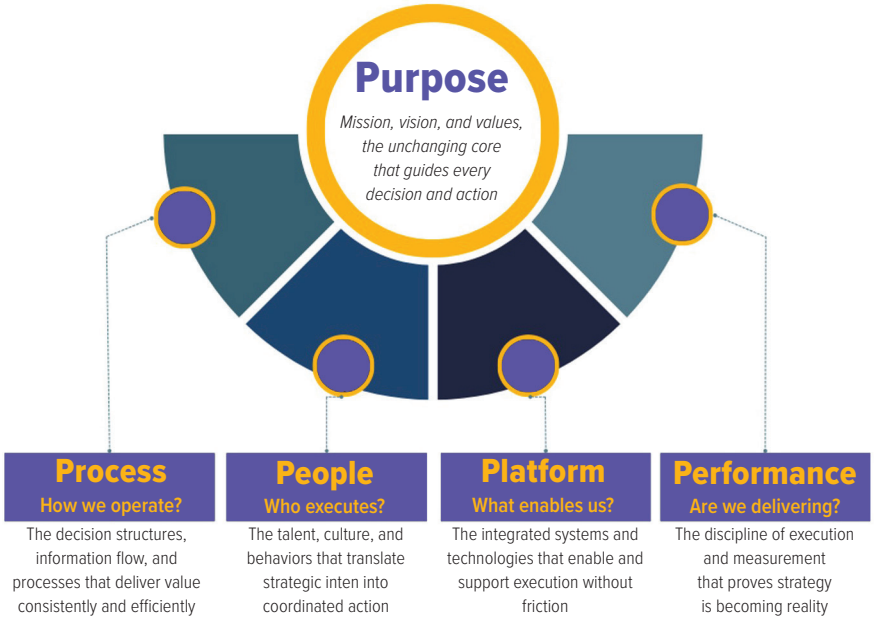
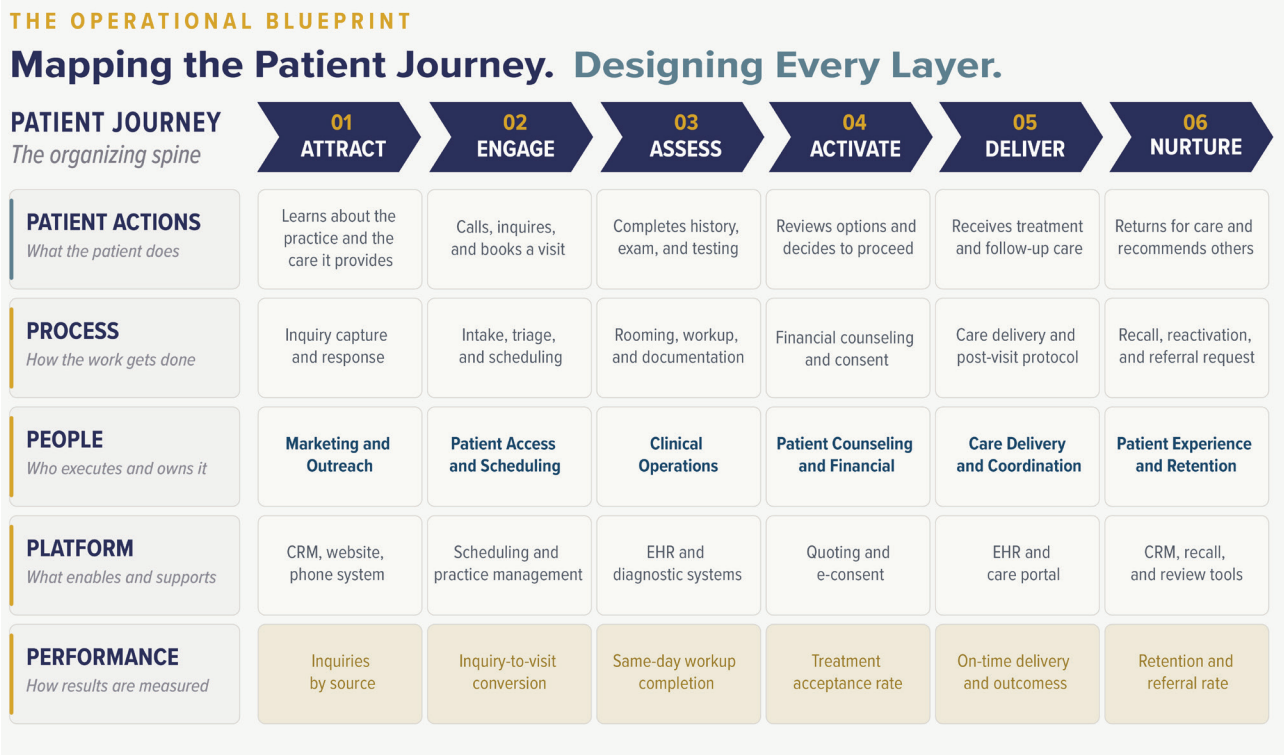


FIGURE 2. OPERATING DOMAINS MAPPED TO THE PATIENT JOURNEY



technology and measures connect at every point.

The sections that follow show how to define each domain around the patient journey and what practice leaders may uncover in the process.

USE THE PATIENT JOURNEY AS THE ORGANIZING STRUCTURE

Practice leaders should start by defining the patient journey. This is a leadership exercise, not just a marketing exercise. The output should be a written sequence, usually six to eight stages, based on how patients actually move through the practice.

Many practices have done some version of this work before. Patient journey mapping documents what the patient experiences and usually stops at the touchpoints. Value stream mapping examines one process end to end and leaves the rest of the operation unaddressed. The approach described here borrows the sequence from both and then specifies four things at every stage: who owns it, how the work is defined, which systems carry it and what gets measured at the handoff. That specification is what turns a map into an operating model.

The stages vary by specialty and care model. A refractive surgery practice may use inquiry, pre-consultation, consultation, post-consultation, pre-surgery, surgery, post-surgery and long-term relationship. A primary care group might use appointment or referral request, scheduling, visit preparation, the visit, follow-up and ongoing care. The exact labels matter less than having a sequence the leadership team agrees on and uses for subsequent operational work.

Leaders often disagree about where one stage ends and the next begins. That is useful. If leadership cannot define a handoff, staff are probably navigating it without a shared standard. Figure 2 shows the four operating domains mapped across the full journey. Each column is a stage, each row is a domain, and each cell shows what that domain looks like at that point in the journey. The example is procedure-oriented; other specialties should substitute stages and measures that fit their own workflows.

PURPOSE: THE STRATEGIC FOUNDATION

Purpose includes mission, vision and values. Mission defines what the practice does and for whom. Vision defines where the organization is headed. Values should guide day-to-day behavior and decisions.

In many practices, these statements are visible but have little effect on day-to-day

operations. They stay aspirational instead of being translated into clear operating expectations. A value cannot help resolve a scheduling conflict, staffing shortage or capital request unless leaders define what it requires in those situations.

Purpose becomes operational when leaders can state what it requires at each stage of the patient journey. A commitment to access might set a response-time standard for appointment requests. A commitment to informed decision-making might set expectations for how clinicians and staff explain treatment options. A commitment to continuity might define when and how follow-up occurs. Those are measurable expectations, not just statements of intent.

Purpose also helps when priorities compete. Leaders can ask which option best advances the mission, moves the practice toward its vision and reflects its values. When those expectations are clear, managers and teams have a better basis for routine decisions without escalating every choice to senior leadership.

PROCESS: DEFINE WORKFLOWS STAGE BY STAGE

The Process domain covers how work gets done. Many practices have documented procedures, but they do not always specify the steps, handoffs and standards clearly enough to guide daily work.

Mapping Process to the journey means documenting what happens at each stage, in what order and to what standard. At the inquiry or appointment-request stage, that may include call handling, referral or request capture, source tracking where relevant, and response time. At the assessment stage, it may include check-in, intake, diagnostic testing, examination and documentation of the clinical recommendation. The point is to define the work at a level staff can actually follow.

Transitions between stages need the same attention. A handoff is complete only when the next team has the information and prerequisites it needs to begin without retracing prior work. Define what information moves, where it is documented and who confirms the handoff.

This exercise often exposes handoffs that rely on assumption instead of a defined transfer. Information may stay with the person who gathered it, in an inbox, spreadsheet or personal note the next team cannot see. The gap becomes visible only when follow-up stalls, a patient has to repeat information or the practice loses track of the next step.

PEOPLE: ASSIGN ACCOUNTABILITY BY STAGE

The People domain answers two questions: who does the work, and who is accountable for the outcome? Practices usually answer the first more clearly than the second.

Medical practice roles are usually defined by function: front desk or patient access, clinical staff, care coordination, procedural teams, billing and others. Each has a supervisor responsible for that function.

Mapping People to the journey adds stage ownership. Each stage should have a named owner accountable for the patient's progress through it. That owner may not supervise everyone involved; a stage can span several departments. The point is to make someone responsible for the stage outcome and its handoffs, even when reporting lines cross.

This addresses a common gap in department-based organizations: accountability can stop at the edge of a team. Each function completes its task, but no one owns the transition to the next step. Stage ownership makes those handoffs part of someone's responsibility.

Leaders should expect to find some stages with several possible owners and others with no obvious owner. Both are useful findings: they show where the practice is relying on individual initiative rather than defined accountability.

PLATFORM: MAP THE SYSTEMS THAT SUPPORT THE WORK

The Platform domain covers the systems and technology that support the work. Practices often evaluate tools by category: the practice management system, EHR, phone system, patient engagement platform, customer relationship management system or other applications, and ask whether each works well on its own.

Mapping Platform to the journey asks different questions: which systems support each stage, and where does patient information move between them? This view often produces some of the quickest opportunities for improvement.

A visible performance problem may lead first to measurement, which points to process or ownership gaps. A workflow review may expose technology or accountability problems. Whatever the starting point, keep the work organized around the patient journey so the findings connect instead of falling back into departmental silos.

Two patterns are common. One is a stage that depends on several systems that do not exchange information, forcing staff to reconcile data manually. That work may not be documented, staffed or measured. The other is a stage with no reliable system of record, where information lives in personal notes, informal lists or memory.

Both create operational risk that a system-by-system technology review can miss. The problem sits at the handoff between tools, where patient information has to move.

A journey map can also sharpen technology decisions. Instead of asking which product has the best feature list, leaders can ask which stage an investment improves, which handoff it fixes and what operational result should change. That is a clearer basis for prioritizing technology spending.

PERFORMANCE: MEASURE PROGRESS, NOT JUST ACTIVITY

The Performance domain asks whether the practice is getting the intended results. Productivity by role and volume by department remain useful, but they mainly describe activity. They do not show where patients are moving smoothly or getting stuck.

Measurement by journey stage should include operational and business indicators, plus clinical indicators where appropriate. Operational measures show how the stage is performing: response time, no-show rate, completion of pre-visit or pre-procedure requirements and on-time starts. Business measures show what the stage produces: appointments scheduled, procedures booked, referrals generated or expected revenue tied to scheduled care. Clinical measures show outcomes where relevant. The mix should reflect the practice's specialty and goals.

Handoffs need measures, too. Two useful measures are progression (or conversion, where appropriate) and time to the next stage. Progression shows the share of patients who move from one stage to the next; time to the next stage shows how long that takes.

These measures can serve as early warning signs. Procedure or visit volume reflects decisions made earlier in the journey. A drop in progression or a longer time to the next stage can signal future volume problems while leaders still have time to act.

A practice may see stable consultation or visit volume and assume operations are sound even as fewer patients move to the next needed step. Measuring the transitions can reveal that decline earlier.

PUTTING THE MODEL TO WORK

The value comes from connecting the domains, not completing five separate exercises. A practice can map the journey, assign stage owners, document workflows, inventory systems and establish measures and still gain little if each remains a standalone project. The pieces need to line up: a stage owner accountable for a defined process, supported by the right systems, measured against clear results and tied back to the practice's purpose.

Practices do not have to start in the same place. A visible performance problem may lead first to measurement, which points to process or ownership gaps. A workflow review may expose technology or accountability problems. Whatever the starting point, keep the work organized around the patient journey so the findings connect instead of falling back into departmental silos.

An operating model does not replace management judgment. It gives leaders a shared way to organize decisions and see how a choice in one area affects the others. That consistency is what fragmented operations lack. ■

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